STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Raul Pino, M.D., M.P.H.
Commissioner

Dannel P. Malloy
Governor
Nancy Wyman
Lt. Governor

Healthcare Quality And Safety Branch

November 1, 2018

Mr. John Rodis, M.D., Administrator
St Francis Hospital & Medical Center
114 Woodland Street
Hartford, CT 06105

Dear Mr. Rodis, M.D.:

An unannounced visit was made to St Francis Hospital & Medical Center on September 26, 2018 by representatives of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting an investigation.

Attached is the violation of the Regulations of Connecticut State Agencies and/or General Statutes of Connecticut which was noted during the course of the visit.

In accordance with Connecticut General Statutes, section 19a-496, upon a finding of noncompliance with such statutes or regulations, the Department shall issue a written notice of noncompliance to the institution. Not later than ten days after such institution receives a notice of noncompliance, the institution shall submit a plan of correction to the Department in response to the items of noncompliance identified in such notice.

The plan of correction is to be submitted to the Department by November 15, 2018.

The plan of correction shall include:

(1) The measures that the institution intends to implement or systemic changes that the institution intends to make to prevent a recurrence of each identified issue of noncompliance;

(2) the date each such corrective measure or change by the institution is effective;

(3) the institution's plan to monitor its quality assessment and performance improvement functions to ensure that the corrective measure or systemic change is sustained; and

(4) the title of the institution's staff member that is responsible for ensuring the institution's compliance with its plan of correction.

The plan of correction shall be deemed to be the institution's representation of compliance with the identified state statutes or regulations identified in the department's notice of noncompliance. Any institution that fails to submit a plan of correction may be subject to disciplinary action.

DATE OF VISIT: September 26, 2018

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

You may wish to dispute the violations and you may be provided with the opportunity to be heard. If the violations are not responded to by **November 15, 2018** or if a request for a meeting is not made by the stipulated date, the violations shall be deemed admitted.

We do not anticipate making any practitioner referrals at this time.

If there are any questions, please do not hesitate to contact this office at (860) 509-7400.

Respectfully,

SNN

Susan Newton, RN, BS
Supervising Nurse Consultant
Facility Licensing and Investigations Section

SHN/PAB:jf

Complaint #24111 & #24098

DATE OF VISIT: September 26, 2018

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (c) Medical staff (2)(B) and/or (4)(A) and/or (d) Medical records (3) and/or (e) Nursing Service (1).

1. Based on a review of clinical records, interview and policy review, for one of three patients admitted with suicidal ideation (Patient #4), the facility failed to develop a comprehensive discharge plan to ensure continuity of care. The finding includes the following:
   a. Patient #4 was brought to the ED on 9/15/18 at 1:40 PM via EMS from the police department for "feeling depressed and suicidal". The record indicated that the patient was placed on constant observation at 1:45 PM. Review of the physician's note dated 9/15/18 at 2:28 PM indicated that the patient was in police custody, in handcuffs, for violating parole. The patient had a history of depression and a previous suicide attempt. The patient was noted to be non-compliant with his/her medication and had a substance abuse history. The physician further documented that the patient thinks about hurting self but denies a plan for self-harm and would be evaluated by the crisis team.

      Review of the Suicide/Safety Assessment dated 9/15/18 at 4:52 PM conducted by the crisis Social Worker noted the patient had suicidal ideation without a plan, exhibited no morbid ruminations, and was moderately depressed with a severe sense of shame and worthlessness. The assessment further identified that the patient continued to endorse thoughts of suicide but had insight into behaviors that lead to his/her lockup, appeared to be reporting thoughts of suicide then recanted secondary to being placed in jail for an undetermined amount of time. The patient was under a warrant and would remain in custody of police department (PD). A recommendation was made that the patient remain in custody of the PD, that suicidal thoughts are secondary to realization of current status and the patient will return to jail with suicide precautions in place. The case was discussed with the Psychiatrist.

      The MD assessment at 9/15/18 at 5:33 PM indicated that the patient was medically stable, had been seen by crisis and deemed stable from that perspective and had no concerns about the patient's safety as the patient was in police custody under a warrant and was discharged in police custody.

      The nurse's note dated 9/15/18 at 5:49 PM noted that the patient was tearful but ok for discharge and that the nurse discussed with police that patient was cleared by crisis but encouraged to keep a close eye on the patient. The note indicated that the patient departed in police custody in shackles back to lockup.

      Review of the discharge instructions provided to the patient indicated the reason for the ED visit was suicidal and depression with diagnoses of bipolar disorder, alcohol, and drug use.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

Attached information included information of bipolar disorder, and drug abuse. The patient was instructed to follow-up with pediatrics as needed.

Review of clinical record dated 9/15/18 at 6:00 PM indicated that the patient was found laying on the floor in a bathroom in the ED with socks tied tightly around his/her neck. The socks were immediately loosened and was noted with a patent airway. The patient was hemodynamically stable. The patient was admitted to trauma service under continuous observation. The record identified that the patient was discharged to a state correctional institution on 9/18/18.

Interview with the Director of Crisis on 9/26/18 at 2PM stated staff could have arranged for the patient to be arraigned at the hospital and remanded to the appropriate level of service, however, this option was not explored. In addition, although the patient was in police custody and evaluated by the crisis worker, the discharge plan transition plan was geared towards the patient returning home and not to a correctional institution/jail.

Review of the Transition/Discharge planning policy identified that the discharge planning process addresses all transitions between levels of care with an emphasis on continuity of care. The Case Manager or Social Worker are responsible to provide oversight to the support staff to ensure all elements of the transition plan are implemented and communicated to the patient, family, hospital staff, or physicians and multidisciplinary healthcare team, and accepting agency/facility. The discharge plan should address all transitions between levels of care and be documented in the clinical record.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (d) Medical records (3) and/or (e) Nursing Service (1).

2. Based on clinical record review, facility documentation and interviews for one of three sampled patients (Patient #3) reviewed for pain assessment, the facility failed to ensure a pain assessment was conducted according to facility policy. The findings include:
    a. Patient #3 went to the emergency department (ED) on 9/25/18 for complaints of testicular pain; the patient had been seen in an urgent care setting earlier and prescribed antibiotics for possible epididymitis and now presents with worsening symptoms. Review of the ED provider assessment notes identified fatigue, fever and testicular pain. An ultrasound of the scrotum reported acute left orchitis. The ED notes identified recommendation to continue antibiotics and ibuprofen for pain relief.

    Review of the vital sign flow sheet identified assessments for temperature, pulse, respiration and blood pressure at 4:20PM and 6:12PM. The flow sheet failed to identify documentation

for pain assessments.

In an interview with the Director of Nurses on 9/26/18 identified it is the expectation for a pain assessment to be conducted on admission to the ED by the RN.

Review of the ED nursing assessment, plan of care and documentation guidelines policy identified in part the primary assessment by the RN will ensure that a complete set of vital signs including a pain score are obtained based upon chief complaint and presenting symptoms.

Approved
SHN
11/15/18

Trinity Health
Of New England

November 15, 2018

Susan Newton, R.N., B.S.
Supervising Nurse Consultant
Facility Licensing Investigations Section
State of Connecticut Department of Public Health

Dear Ms. Newton,

Attached is the Corrective Action Plan, in response to the violation letter dated November 1, 2018 following a visit to Saint Francis Hospital and Medical Center on September 26, 2018, by representatives of the Facility Licensing and Investigations Section of the Department of Public Health.

If you have any questions related to this document, please contact me at (860) 714-1572

Thank you,

Monica Peyman

Monica Peyman, MS, NHA, CPHQ, CPPS, CJCP
mpeyman@stfranciscare.org
Director of Quality, Patient Safety and Regulatory Affairs
Saint. Francis Hospital and Medical Center

DATE OF VISIT: September 26, 2018

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Review of the Transition/Discharge planning policy identified that the discharge planning process addresses all transitions between levels of care with an emphasis on continuity of care. The Case Manager or Social Worker are responsible to provide oversight to the support staff to ensure all elements of the transition plan are implemented and communicated to the patient, family, hospital staff, or physicians and multidisciplinary healthcare team, and accepting agency/facility. The discharge plan should address all transitions between levels of care and be documented in the clinical record.

Corrective action:
On behalf of the Behavioral Health Chairman, Crisis Manager, Emergency Department Chairman and Emergency Department Nursing Director, the Transition/Discharge Planning Policy, CM 2.014 was sent to the Consultation Liaison Service staff, Emergency Physician staff, Emergency RN staff, and Crisis staff responsible for discharge of behavioral health patients, for their review in order to reinforce staff knowledge and compliance regarding appropriate discharge planning for safe patient transitions and continuity of care of the behavioral health patient. This re-education will be completed by November 15, 2018.

Ongoing medical record audits will be conducted for 3 months on no less than 30 behavioral health patients discharged from the Emergency Department either to home or transferred to another facility, to ensure that responsible staff are compliant with the Transition/Discharge Planning Policy, CM 2.014.
Feedback will be provided to those staff who do not comply with the stated Policy to include additional education as needed, and/or disciplinary action as appropriate.
Audits will be initiated by November 15, 2018.
Responsible Party: Nursing Director of Emergency Department

DATE OF VISIT: September 26, 2018

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   In an interview with the Director of Nurses on 9/26/18 identified it is the expectation for a pain assessment to be conducted on admission to the ED by the RN.

   Review of the ED nursing assessment, plan of care and documentation guidelines policy identified in part the primary assessment by the RN will ensure that a complete set of vital signs including a pain score are obtained based upon chief complaint and presenting symptoms.

Corrective Action:

On behalf of the Emergency Department Executive Director, the Emergency Department (ED) Nursing Assessment, Plan of Care, and Documentation Guidelines, CLIN.0394 was sent to the Emergency RN staff for their re-education and review in order to reinforce staff knowledge and compliance regarding pain assessment and reassessment. This re-education occurred by November 15, 2018. ✓

Ongoing medical record audits will be conducted for 3 months on no less than 30 emergency department patients to ensure that responsible staff are compliant with the (ED) Nursing Assessment, Plan of Care, and Documentation Guidelines, CLIN.0394. Feedback will be provided to those staff who do not comply with the stated Policy to include additional education as needed, and/or disciplinary action as appropriate. Audits will be initiated by November 15, 2018.

Responsible Party: Nursing Director of Emergency Department